June 2012

# Montana Central Tumor Registry Newsletter

MONTANA CANCER CONTROL PROGRAMS
MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

## Preliminary Audit Observations

The MCTR December 2011 Newsletter's cover page article described an audit that the MCTR was going to undergo the spring of 2012.

This audit was conducted by ICF Macro under contract with the CDC May 7-18. The auditors re-coded 23 data fields based solely on reported text from hospitals and pathology. The cases included female breast, colorectal, lung, prostate, and corpus uteri diagnosed in 2009.

Of 200 cases re-coded, there were a total of 107 cases with coding differences between what the text described and what was coded. Of those 107 cases, 170 fields had differences. Some cases had more than one difference. Most differences occurred on Collaborative Stage and Treatment fields. The MCTR was able to "explain away" most of the 170 differences with text that the auditors did not find.

| Primary Site | # re-coded | Cases w/ differences | # of differences |
|---|---|---|---|
| Colorectal | 42 | 21 | 32 |
| Lung | 29 | 17 | 37 |
| Breast | 68 | 40 | 58 |
| Uterus | 16 | 4 | 6 |
| Prostate | 45 | 25 | 37 |
| Total | 200 | 107 | 170 |

Preliminary observations after reconciliation include these items:

- Path text boxes often did not describe LN chains for colon cases
- Treatment text boxes often did not include dates
- Surgery text boxes did not describe the specific type of surgery
- Radiation text boxes did not describe radiation modality
- Chemotherapy text boxes often did not describe dates or drugs
- Grade codes for breast cases were assigned using the wrong table
- Clinical extension for prostate cases did not describe whether the cancer was apparent or in-apparent at clinical diagnosis

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# Meet the Registrar

Starla Mallery and grandson, Canaan
Clark Fork Valley Hospital, Plains

I am Starla Mallery, I have been the tumor registrar for Clark Fork Valley Hospital for almost 13 years. I am also the coder for all outpatient lab and radiology and for the Plains Family Medicine Clinic. After studying for 2 plus years doing online classes and a lot of reading on my own, I sat for and passed the CPC certification test through AAPC in March of this year.

I am married and have 2 children, my daughter Mandy is a master's level mental health therapist, her husband Seth recently returned from a tour of duty in Iraq. My son Brian just graduated from MSU with a photography degree and his new bride, Megan, is working on her masters in Architecture.

The real love of my life (next to my husband) is my grandson Canaan. My daughter and her husband adopted him from Ethiopia when he was 11 months old, two years ago. I got to go with them and experience an amazing time in Africa, meeting my grandson and seeing a world far different than Montana.

In my almost non existent spare time, I love painting, reading and writing children's stories with my husband. He has the imagination and I am his transcriptionist!

# Audit Observations continued

Of course, the described observations do not apply to all hospitals.

We will say it again: complete text is critical in your abstracts! Reviewing your text against assigned codes is not done to prove you wrong—it's done to prove you **right**!

Text fields are required by the MCTR for two reasons: it is described in the Administrative Rules of Montana 37.8.1802 and it is required by the CDC as part of our cooperative agreement. Instructions and examples for documenting text are in the MCTR Reporting Manual.

As a result of this learning process, the MCTR will be publishing a document exclusively for writing text for all free-text fields. Be looking for this document in the next month or so.

# SEER * Rx

The SEER*Rx Interactive Drug Database was updated on May 4, 2012. This version includes 10 new regimens, 10 drugs recently approved by the FDA, and 7 new drugs. All of the newly added drugs are currently in clinical trials (Phase I, Phase II, or Phase III) and have not received final FDA approval as accepted treatment for cancer.

SEER*RX is now available in two formats: a web-based tool and as stand-alone software.

**Web-based Version**

The **SEER*Rx - Interactive Antineoplastic Drugs Database** is provided in a web-based format that has several benefits over the software:

- Updates are automatic: users do not have to install anything to access the latest revisions.
- Allows access from any computer or device with an Internet connection.
- Eliminates problems for users who do not have permission to install software on their work computers.

**Download Software Version**

The web-based version of the SEER*Rx is the preferred method to access the current data. If you need the software version because of limited Internet access, it is still available for now, but may be phased out in the future. Note that the coding information in the software version of the database can get out-of-date; be sure to check back to this site to install any updates. To download the SEER*Rx Version 2.0.0, go to https://seer.cancer.gov/tools/seerrx/download.

# Certificate of Excellence Recipients

The following facilities received a certificate for the 2012 First Quarter, acknowledging their timeliness in reporting. Ninety percent of their cases were reported within 12 months.

| Facility | City |
|---|---|
| **Physicians:** | |
| Tallman Dermatology | Billings |
| Advanced Dermatology of Butte | Butte |
| Dermatology Assoc of Great Falls | Great Falls |
| Associated Dermatology | Helena |
| Dermatology Associates | Kalispell |
| **Hospitals:** | |
| Billings Clinic | Billings |
| Bozeman Deaconess Hospital | Bozeman |
| Madison Valley Hospital | Ennis |
| MT VAMC | Fort Harrison |
| Frances Mahon Deaconess Hospital | Glasgow |
| Glendive Medical Center | Glendive |
| Sletten Cancer Center | Great Falls |
| Northern Montana Hospital | Havre |
| Kalispell Regional Medical Center | Kalispell |
| Central Montana Medical Center | Lewistown |
| St. Patrick Hospital | Missoula |
| Clark Fork Valley Hospital | Plains |
| Roundup Memorial Healthcare | Roundup |

# Melanoma—Q & A

Source: NAACCR Webinar 05/03/2012

Q Often when an excisional biopsy is taken and the margins aren't clear this is coded as a biopsy, but the doctor's intent was to get clear margins. This should be considered first course of treatment, correct?
A You would code the excisional biopsy as surgery, not as diagnostic staging procedure.

Q For primary unknown metastatic melanoma, you indicated that lymph nodes and subcutaneous/skin metastasis are regional unless there are other metastases. To clarify, if there are lymph node metastases and liver metastases, are the lymph nodes coded regional and the liver coded distant?
A If there is positive lymph node and liver metastasis, code the lymph node as regional and the liver mets as CS Mets at DX.

Q Rule M6 for melanoma states: 'An invasive melanoma that occurs more than 60 days after an in situ melanoma is a multiple primary.' What if treatment (re-excision) was planned and occurred more than 60 days after the diagnosis? Would this be 1 or 2 primaries?
A If there was a separate invasive tumor identified more than 60 days after the diagnosis of the in situ melanoma, it would be 2 primaries.- If biopsy is in situ melanoma and re-excision more than 60 days after the biopsy is part of planned first course treatment and identified invasive melanoma that is part of the original tumor, it should be all coded as 1 invasive primary.

Q Is the Breslow depth the same as vertical growth phase?
A Not really. Breslow depth of the tumor is depth of invasion of the tumor recorded in mm. Vertical growth phase means the tumor is in a growth phase where it is growing down into skin.

Q When coding clinical lymph nodes in SSF 3, do you use the reportable descriptors (malignant, suspicious for malignancy, etc.) to code clinical involvement?
A Lymphadenopathy alone without a reportable descriptor is not enough to consider lymph nodes clinically involved. However, a clinical satellite lesion would be considered clinical involvement.

Q If the procedure is stated as wide excision with 1 cm margin what code would you use?
A Use code 30.

Q If at wide excision there is no residual melanoma, what is the code for the shave, punch, incisional biopsy? And what is the code for the wide excision?
A The code for the original excisional biopsy would be 27 regardless of whether it was a shave, punch, or excisional biopsy (couldn't be an incisional if there was no residual carcinoma). The code for the wide excision would depend on what the margins were. If 1cm or less, they would be based on the type of excisional biopsy. If margins are more than 1cm, they would depend on how much of a negative margin was present. See the coding guidelines below.

Q If a wide excision is done and margins are negative but it is not stated how far wide margins are (1, 2, etc.) do we assume its 1cm or less?
A You would not assume they are more than 1cm. Therefore, you would not use codes 45, 46, or 47.

Q If a punch or shave biopsy done on 1/15/11 is followed by a wide excision on 1/30/11, would you code the first procedure as 27 or 30-33?
A The first procedure as a 27 and the second procedure as a 32.